MAIL-IN REFILL PRESCRIPTION REQUEST

Patient's printed name:

Date: | Sponsor's social security number:

DUNHAM U.S. ARMY HEALTH CLINIC PHARMACY
CARLISLE BARRACKS, MD 17013 PH. 245-4509
KEEP OUT OF THE REACH OF CHILDREN

942764 JONES, JOHN P
SMITH, JOHN
TAKE ONE TABLET EVERY 4 HOURS

Note: Prescription expires 1 year from this date; 6 months for controlled prescriptions.

ASPIRIN 325MG TABLET

REFILLS 5 (03/17/90)

QTY: 30 TAB
MLU (04/17/90)

PRESCRIPTION NO.	MEDICATION	QUANTITY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please allow 10 working days to pick up.

Thank You!

MEDDAC (Ft Meade) Form 549, 1 Feb 03 Previous editions are obsolete.

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---------- FOLD HERE

AFFIX
FIRST CLASS
POSTAGE
HERE

COMMANDER
DUNHAM US ARMY HEALTH CLINIC
ATTN MCXR CBK (PHARMACY REFILL SERVICE)
450 GIBNER ROAD SUITE 1
CARLISLE BARRACKS PA 17013-5003

Fasten Here
(with tape)

---------- FOLD HERE

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FIRST CLASS
POSTAGE
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